

UNITED STATES PATENT APPLICATION

of

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and

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for a

SURGICAL INSTRUMENT

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SURGICAL INSTRUMENT

PRIORITY INFORMATION

The present application is a continuation of and claims priority to International
5 Application PCT/US00/12553 filed on May 9, 2000, which designates the U.S. and in turn
claims priority to U.S. Provisional Patent Application Ser. No. 60/133,407 filed on May 10,
1999.

BRIEF DESCRIPTION OF THE DRAWINGS

10 The following description may be further understood with reference to the
accompanying drawings in which:

FIG. 1 shows a perspective view of a minimally invasive surgical system including a
surgical instrument of the present invention;

15 FIG. 2 shows a functional schematic diagram of the surgical adaptor component of the
system of Figure 1;

FIG. 3 shows a functional schematic diagram of the instrument insert component of the
system of Figure 1;

FIG. 4 shows a perspective view of the surgical instrument insert component of the
system of Figure 1;

20 FIG. 5 shows a perspective view of the coupler component of the system of Figure 1;

FIG. 6A – 6B show perspective views of the end-effector component of the system of
Figure 1;

FIG. 7A – 7C show exploded perspective views of the surgical instrument adaptor
component of the system of Figure 1; and

FIG. 8 shows a perspective view of the modular drive unit used in the system of Figure 1; and

FIG. 9 shows detailed drawings of the connector components of the surgical adaptor used in the system of Figure 1.

5 The drawings are for illustrative purposes only and are not to scale.

DETAILED DESCRIPTION OF THE ILLUSTRATED EMBODIMENTS

10 The present invention provides an instrument system that may be used to perform minimally invasive surgery. An exemplary system of the invention is actuated by a flexible cable assembly as shown in Figures 1 - 9. Generally, the cable assembly is in the form of an array, and is removably attached to an actuation drive unit. The actuation drive unit is remote from the operative site and is preferably positioned a distance away from the sterile field. The drive unit is electrically controlled by a computer system that is connected to a user interface. Commands issued at the user interface are translated by the computer into electronically driven motion in the drive unit. The surgical instrument, which is tethered to the drive unit through its cable connection, produces the desired motion.

15 The surgical instrument is generally composed of two components - a surgical adaptor and an instrument insert. The surgical adaptor is a passive mechanical device, driven by the attached cable array. Since the surgical adaptor is detachable and relatively simple, it may be designed for particular surgical applications, such as abdominal, cardiac, spinal, arthroscopic, sinus, neural, etc. The surgical insert couples to the adaptor and essentially provides a means for exchanging the instrument end-effectors. These inserts may include forceps, scissors, needle drivers, electrocautery, etc.

Referring specifically to Figure 1, a surgical instrument system 10 may preferably be

used to perform minimally invasive procedures, although it is to be understood that the system may be used to perform other procedures as well, such as open or endoscopic surgical procedures. The system 10 includes a surgeon's interface 11, computation system 12, drive unit 13 and a surgical instrument 14. The surgical instrument 14 is comprised of a surgical adaptor 15 and instrument insert 16. The system may be used by positioning the end effector 18 of the instrument insert 16, which is inserted through the surgical adaptor 15. During use, a surgeon may manipulate the handle 30 of the surgeon's interface 11, to effect desired motion of the end effector 18 within the patient. The movement of the handle 30 may be interpreted by the computation system 12 to enhance the movement of the end effector.

The system may also include an endoscope with a camera to remotely view the operative site. The camera may be mounted on the distal end of the instrument insert, or may be positioned away from the site to provide additional perspective on the surgical operation. In certain situations, it may be desirable to provide the endoscope through an opening other than the one used by the surgical adaptor 15.

The surgical instrument 14 is preferably mounted on a rigid post 19, which is movably affixed to the surgical table 20. This preferable mounting scheme permits the instrument to remain fixed relative to the patient if the table is repositioned. Although Figure 1 depicts a single surgical instrument, it is to be understood that the system may have any number of instruments.

The surgical adaptor 15 of the surgical instrument 14 includes two mechanical cable-in-conduit bundles 21 and 22. These cable bundles 21 and 22 terminate at two connection modules 23 and 24, which removably attach to the drive unit 13. Although two cable bundles are described here, it is to be understood that more or fewer cable bundles may be used. The drive unit 13 is preferably located outside the sterile field, although it may draped with a sterile

barrier so that is may be operated within the sterile field.

In the preferred method to setup the system, the surgical instrument 14 is inserted into the patient through an incision or an opening. The instrument 14 is then mounted to the rigid post 19 using a mounting bracket 25. The cable bundles 21 and 22 are then passed away from the operative area to the drive unit 13. The connection modules 23 and 24 of the cable bundles 21 and 22 are then engaged onto the actuation unit 13. Instrument inserts 16 may then be passed through the surgical adaptor 15. The surgical inserts 16 are coupled laterally with the surgical adaptor 15 through the adaptor coupler 24.

The instrument 14 is controlled by the interface handle 30, which may be manipulated by the surgeon. Movement of the handle may produce proportional movement of the instrument 14 through the coordinating action of the computation system 12. In the typical case, movement of a single hand controls movement of a single instrument. Figure 1, shows a second handle that may be employed to control an additional instrument.

The surgeon's interface 30 is in electrical communication with the computation system 12, and the computation system 12 is in electrical communication with the actuation unit 13. The actuation unit 13, however, is in mechanical communication with the instrument 14. The mechanical communication with the instrument allows the electromechanical components to be removed from the operative region, and preferably from the sterile field. The surgical instrument 14 provides a number of independent motions, or degrees-of-freedom, to the end effector 18. These degrees-of-freedom are provided by both the surgical adaptor 15 and the instrument insert 16.

The surgical adaptor 15, shown schematically in Figure 2, provides three degrees-of-freedom, which are achieved using a pivotal joint J1, a linear joint J2, and a rotary joint J3. From the mounting bracket 23, shown in schematically Figure 2., a pivotal joint J1 pivots the

surgical adaptor assembly about a fixed axis 204. A first linear joint J2, moves the guide tube 200 along an axis 201 defined by the tube. A rotary joint J3 rotates the guide tube 200 its long axis 201. The guide tube 200 has a bend 202 that causes the distal end of the tube to orbit the axis 201 when the guide tube is rotated about its axis.

5 Through a combination of movements at joints J1 – J3, the surgical adaptor 15 can position its distal end 203 to any desired position in three-dimensional space. By using only a single pivotal motion, the external motion of the surgical adaptor 15 is minimized. Furthermore, the pivotal axis 204 and the longitudinal axis 201 intersect at a fixed point 205. At this fixed point 205, the lateral motion of the guide tube 200 is essentially zero.

10 Figure 3 shows a schematic representation of the kinematics of the instrument insert 16. The instrument insert 16 is placed through the surgical adaptor 15, so that the movements of the insert are added to those of the adaptor. The instrument insert 16 has two grips 304 and 305, which are rotatably coupled to wrist link 303 by two rotary joints J6 and J7. The axes of joints J6 and J7 are essentially collinear. The wrist link 303 is coupled to a flexible shaft 302 through a rotary joint J5, whose axis is essentially orthogonal to the axes of joints J6 and J7. 15 The flexible shaft 302 is attached to a rigid shaft 301. The rigid shaft 301 is rotatably coupled by a joint J4 to the instrument insert base 300. The axis of joint J4 is essentially co-axial with the rigid shaft 301.

20 The combination of joints J4 – J7 allow the instrument insert 16 to be actuated with four degrees-of-freedom. When coupled to the surgical adaptor 16, the insert and adaptor provide the surgical instrument 14 with seven degrees-of-freedom. Although four degrees-of-freedom are described here for the insert 16, it is to be understood that greater and fewer numbers of degrees-of-freedom are possible with different instrument inserts. For example, an energized insert with only one gripper may be useful for electro-surgery applications, while an insert with

an additional linear motion may provide stabilizing capability.

The instrument insert 16, shown in FIG. 4, is comprised of a coupler 401, a rigid stem 402, a flexible section 403 and an end effector 404. The coupler 401 includes one or more wheels 405 which laterally engage wheels 726 of the coupler section 700 on the surgical adaptor 15. The coupler 401 also includes an axial wheel 406, which also engages a wheel on the adaptor. The axial engagement wheel 406 is fixed to the rigid stem 402, and is used to rotate the end-effector axially at the distal end of the flexible section.

A detail of the coupler assembly 401 is shown in Figure 5. Each wheel 405 of the coupler has two cables 500 and 501 that are affixed to the wheel and wrapped about opposite sides at its base. The lower cable 500 also rides over an idler pulley 502, which routes the cables toward the center of the instrument stem 402. It is desirable to maintain the cables near the center of the instrument stem, since the cables will in accordance with the rotation of the stem. The closer the cables are to the central axis of stem the less disturbance motion on the cables. The cables are then routed through plastic tubes 503 that are affixed to the proximal end of the rigid stem 402 and the distal end of the flexible section 403. The tubes maintain constant length pathways for the cables as they move within the instrument stem.

The end effector, shown in Figures 6A and 6B, is comprised of four members, a base 600, link 601, upper grip 602 and lower grip 603. The base 600 is affixed to the flexible section of the insert stem 403. The link 601 is rotatably connected to the base 600 about axis 604. The upper and lower grips 602 and 603 are rotatably connected to the link about axis 605, where axis 605 is essentially perpendicular to axis 604.

Six cables 606 – 611, shown schematically in Figure 6A, actuate the four members 600 – 603 of the end effector. Cable 606 travels through the insert stem and through a hole in the base 600, wraps on a rounded surface on link 601, and then attaches on link 601. Tension on

cable 606 rotates the link 601, and attached upper and lower grips 602 and 603, about axis 604. Cable 607 provides the opposing action to cable 606, and goes through the same routing pathway, but on the oppose side of the insert.

Cables 608 and 610 also travel through the stem 403 and through holes in the base 600.

5 The cables 608 and 610 then pass between two fixed posts 612. These posts constrain the cables to pass substantially through the axis 604, which defines rotation of the link 601. This construction essentially allows free rotation of the link 601 with minimal length changes in cables 608 – 611. In other words, the cables 608 - 611, which actuate the grips 602 and 603, are essentially decoupled from the motion of link 601. Cables 608 and 610 pass over rounded
10 sections and terminate on grips 602 and 603, respectively. Tension on cables 608 and 610 rotate grips 602 and 603 counter-clockwise about axis 605. Finally, as shown in Figure 6B, the cables 609 and 611 pass through the same routing pathway as cables 608 and 610, but on the oppose side of the instrument. These cables 609 and 611 provide the clockwise motion to grips 602 and 603, respectively.

15 The instrument 16 slides through the guide tube 17 of the adaptor 15, and laterally engages the adaptor coupler 24, as shown in Figures 7A – 7C. The adaptor coupler 24 is pivotally mounted 700 to the guide tube housing 701. The guide tube housing 701 rotationally mounts the guide tube 17. The guide tube housing 701 is affixed to the linear slider 703, which travels along the linear stage 704. The linear stage 704 is pivotally mounted 705 on the
20 base 706.

Cables, which enters the structure through conduits 707, actuate the adaptor 15. The base pivotal joint 705 is control by two cables 708 and 709, which pass over an idler pulley 711 and along opposing directions on base capstan 710. The guide tube capstan 712, affixed to the guide tube 17, and is actuated by cables 715 and 717, which differentially rotates the guide

tube. The axial capstan 713 is rotationally coupled to the guide tube and is actuated by cables 716 and 718. The axial capstan 713 engages the axial engagement wheel 406 on the instrument.

The cables 718 and 719, shown in Figure 7C, actuate the linear slider 703. The cables enter the base 705 through conduits 706 and around idler pulleys 720 and 721. Cable 718 passes freely through the linear slider 703 and around the distal idler pulley 722 and back toward the linear slider 703 onto which it terminates. The cable 719 terminates on the linear slider directly. The engagement wheels 726 located in the adaptor coupler 24 are actuated by cables, which enter the pivotal adaptor coupler 700 guided by idler pulleys 725.

All of the cables in their individual conduits are collected into two bundles 21 that exit the adaptor. These cable bundles terminate on connection modules 22, which are shown in FIG. 8, and removably attach to the motor drive unit. The connection module 22 contains a row of rotatable wheels 900, which engage matching wheels 800 located on the motor drive unit. As shown in Figure 9, each wheel 900 actuates two cables 901 and 902, which wrap about the circumference in opposing directions. An idler pulley 903 aligns one of the cables 902, so that both cables 901 and 902 are in parallel and close together, so that they may be easily fitted into the cable bundle 21.

The connection modules 22 removably attach to the motor drive unit 13. Each wheel of the connection module matches, and is individually actuated by, the corresponding motor drive wheel 800. Notice that the square key 801 on the motor drive wheel matches the detent in the connection module wheel. Each motor drive wheel is fitted to the axle of an electrical motor 802.

With the instrument insert coupled to the surgical adaptor and the connection module fitted to the drive unit, the transmission allows each motor 802 to actuate a single degree-of-

freedom in either the adaptor or the insert. The mechanical assembly thus allows decoupled motion for each degree of freedom. The complete system provides a full seven degrees-of-freedom of motion for the surgical instrument within the body. These degrees-of-freedom include three translational movements in three-dimensional space, three rotational movements
5 allowing arbitrary orientation, and a single grip degree-of-freedom.

It is contemplated that various changes and modifications may be made to the drive unit, cable assembly, surgical adaptor or instrument insert without departing from the spirit and scope of the invention as define by the following claims and their equivalents.

What is claimed is: